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ABSTRACT

The guide is intended to provide an orientation to the individualized, performance based special teacher preparation curriculum at Florida State University. The aim of the curriculum is given to be preparation of teachers to serve in public school resource centers by identifying needs of, providing individualized instruction for, and monitoring performance of mildly handicapped educable mentally retarded, learning disabled, and emotionally disturbed students. It is said that "clinical teaching" (individualizing of instruction) is an historical aspiration for implementing the fundamental philosphy of the right to an education of all children. Dilemmas of special educators during the past twenty years are reviewed in terms of exceptional children, available manpower, provisions and services, clinical teaching, and judicial decisions. Alternative strategies for solving the dilemmas are given in relation to goals, changing concepts, instructional alternatives, and services. The role of the clinical teacher is delineated relative to future competency, procedures such as are found in the instructional system or in task analysis, and individualized instruction by means of a conceptual matching model. Contained in a user's guide are directions for student use of the individualized, performance-based, instructional modules of the program; also, the student's responsibilities are described. Appended are a position statement of performance based teacher education, a sample performance contract, a sample grading scale, and computer management systems transaction logs. (For related information see EC 060 272, EC 060 273, and EC 060 274). (MC)

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WELCOME TO THE SYSTEM

Orientation and Guide to the Clinical Teacher Curriculum

Louis Schwartz and Andrew Oseroff

FALL, 1973

The Florida State University

EC 060 271

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WELCOME TO THE SYSTEM:

Orientation and Guide to the Clinical Teacher Curriculum

Louis Schwartz and Andrew Oseroff

Interrelated Areas of Special Education

Fall, 1973

The Florida State University

A PUBLICATION OF THE CLINICAL TEACHER MODEL SPECIAL PROJECT CONDUCTED BY THE FLORIDA STATE UNIVERSITY, COLLEGE OF EDUCATION, EDUCATIONAL RESEARCH INSTITUTE, PROFESSIONAL AND CLINICAL PROGRAMS, EDUCATION FOR SPECIAL NEEDS, AND SUPPORTED BY A GRANT FROM THE U.S. OFFICE OF EDUCATION, BUREAU OF EDUCATION FOR THE HANDICAPPED, DIVISION OF TRAINING PROGRAMS

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Preface

This WELCOME TO THE SYSTEM is part of a series of publications of the Clinical Teacher Model of Interrelated Areas of Special Education at The Florida State University. The establishment and evaluation of a Clinical Teacher Model is supported by the USOE/BEH/DTP as a Special Project under provisions of P.L. 91-230. The outcome of the research and development activity is an alternative generic non-categorical teacher education program for Special Education. The Model offers a performance-based, criterion-referenced, multimedia, computer-managed, and individualized instructional system. Initial concepts of the Model were developed during the 1969-70 year under provisions of a Program Development Grant (P.L. 85-926). Design of the prototype, individualized instructional modules, computer-management system, and evaluation strategies by the interdisciplinary project staff, marked the first implementation year, 1970-71. Field testing, revision, and evaluation of the Model constitute project activities for 1971-74. Documentation and dissemination is scheduled for 1974-75.

Welcome to the System is designed to provide an orientation and guide for using the *Clinical Teacher Competencies for Special Education.* The outcome of this teacher education curriculum is the preparation of "Clinical Teachers" of mildly handicapped children. Graduates of the five-year, NCATE and State Approved program, are awarded the Bachelor's and Master's Degrees and Florida's Rank 2 Certificate in Exceptional Child Education in four specific areas of: Mental Retardation, Emotional Distrubance, Specific Learning Disabilities, Varying Exceptionalities.

The individualized and performance-based teacher preparation curriculum enables the clinical teacher, functioning in public school resource centers to (1) identify individual pupil entry levels, learner characteristics, and desired outcomes, (2) provide individualized instruction based upon a match of task, learner, and resource characteristics, and (3) monitor pupil and curriculum performance and provide feedback for the ongoing improvement of learning and instruction.

The requisite academic and social behaviors for succeeding in the regular classroom are the desired objectives of special education for mildly handicapped children (educable mentally retarded, learning disabilities, and emotionally disturbed). The clinical teacher competencies of observation, diagnosis, intervention, and evaluation necessary for achieving these outcomes are the products of the teacher education curriculum.

Preparation of the "clinical teacher" for Interrelated Areas of Special Education at The Florida State University represents a decade of planning, design, try-out, and evaluation of an innovative approach to solving the manpower problems and challenges of the field. Linking the best of traditional practices with the most promising technological advances available in instruction, the "clinical teacher" concept and provision offers a viable alternative to the numerous dilemmas confronting special education today. Part I briefly discusses the problems that have confronted special educators during the past twenty years. Part II identifies alternative strategies for solving the dilemmas. The Clinical Teacher Model is presented in Part III. Part IV, A User's Guide, provides procedures and responsibilities for students.

The authors gratefully acknowledge the contributions of Dr. Norm Dodl, Associate Professor of Elementary Education, Florida State University, for his guidance and consultation in the area of performance-based teacher education; and Mrs. Rhea Schwartz, Graduate Research Assistant, for her assistance in the design of the conceptual model for individualizing instruction.

"Clinical teaching," or, *individualzing of instruction* is an historical aspiration for implementing the fundamental philosophy of the right to an education for *all* children.

Individual differences among learners, teachers, and instructional systems will persistently deny the advocacy of a singular alternative to the diverse and complex problems confronting education. Exceptional children and youth and the heritage of special education offer dramatic testimony to this inescapable reality.

The renewed interest and activity in individualizing instruction (clinical teaching in a cascade of services) provides adequate support for the search for alternatives. Innovative models of today run the risk of simply replacing old orthodoxies with new ones unless thoroughly evaluated,

documented, and described as to performance, effectiveness, and efficiency. Above all, early adaptors in colleges and universities, local educational agencies, and state departments of education need to bridge the disparity gap between the realities of changing needs and existing practices. Students, teachers, parents, and administrators must become intimately and inextricably involved in the content and process of change.

> Long before the year 2000, the entire antiquated structure of degrees, majors and credits will be a shambles. No two students will move along exactly the same educational track. For the students now pressuring higher education to destandardize, to move toward super-industrial diversity, will win their battle (Toffler, 1970, p. 272).

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PART I

THE DILEMMA

Educational historians will record the events of the first seventy-five years of the twentieth century as a monumental effort in meeting society's commitment to educate *all* children and youth. Simultaneously with the quantitative growth in educational opportunities for these children, new issues and needs prevented the attainment of traditional goals through existing practices. Special target populations of handicapped and culturally diverse children present an array of academic and social differences that defy any singular approach to their attaining desired educational objectives. Powerful social and political forces such as recent court decisions have demanded that special educators address themselves to change existing practices to meet today's realities of due process for honoring basic commitments for all children. Alternative instructional delivery systems for exceptional children and for the preparation of their teachers have rapidly emerged in response to these changing needs.

While the nineteen fifties and sixties were decades of remarkable growth in efforts to educate the handicapped, this period revealed enormous dilemmas. The persistent gaps between those children served and unserved, professional manpower supply, demand, the nature of their preparation, and, the efficacy of current practices and services illustrate the scope of these problems.

Exceptional Children

Reviewing the prevalance and services for exceptional children from 1922 through 1969, Kirk (1972, pp. 23-30) concluded:

1. Approximately one-half of the children with mental retardation and one-half of the children with speech impairments were being offered special educational services.
2. Approximately one-third of the crippled and one-third of the visually handicapped were being served.
3. Less than one-quarter of the children who were deaf and hard of hearing, or who were emotionally disturbed, or those who had other health handicaps (including specific learning disabilities) were being served.

4. Of the estimated number of all handicapped children combined, only 38 percent or three-eighths were being offered special education services in 1969 (p. 30).

Clearly, the goal of serving all exceptional children remains unfulfilled under current provisions and practices.

Manpower

Shortages of special education teachers and supportive personnel in all areas of exceptionality have paralleled this period. Cruickshank and Johnson (1958) reviewed the factors that led to the "minimal need of 100,000 new special education teachers in 1953-54 (p. 27)," and suggested:

> The shortages of teachers also means that educators in service are going to have to exploit their imagination to the fullest in providing ways to supplement the present available supply of teachers and thus possibly be able to serve more children (p. 28).

Mackie (1962) "estimated that 200,000 are needed and only about 50,000 are available." In addition to the question of numbers, equal concern was voiced over the lack of empirical evidence for existing programs.

> The major roadblock to adequate educational opportunity for these children is the lack of scientifically tested knowledge on how to best provide for these children (p. 1).

Kirk (1965) summarized these needs and offered the following suggestions:

> Under the pressure of extreme shortages of professional personnel, a major issue becomes whether to (a) focus on immediate needs in terms of the numbers of special educators without regard to quality; (b) concentrate on quality in the preparation of professional personnel, even though it may mean a decrease in the numbers thus prepared; or (c) find a radically new method of accomplishing both goals at the same time (p. 102).

Heller (1968) stressed "quality preparation" as the basic objective of the federally funded teacher education programs for special education personnel. Reporting that "... 177 students participated in this program in 1960, 4,910 in 1964, and 11,593 in 1967 (p. 540)," Heller, also indicated that at least sixty percent of the nation's exceptional children continue to receive less than adequate special educational services. Striving

for the reduction of this gap and for the "... continued improvement of professional preparation programs" Heller pledged the support of the Division of Training Programs as an instrument for encouraging "needed change" within colleges and universities.

Provisions and Services

Enabling legislation authorizing special educational services has produced organizational patterns with programs and instruction based upon medical and psychological categories. By the 1960's concern was expressed over the lack of evidence of the efficacy of this system. Sporadic questioning of this practice emerged as new categories such as "brain-injured," "learning disabilities," "emotionally disturbed," "multiply handicapped," and others were added; these new categories increased the concern of those who were already criticizing existing practices.

Gallagher (1960) and Cruickshank, et al, (1961) clearly questioned the relevance of the term "brain-injured" for educational planning. Trippee (1966) highlighted this concern by extending the problem to teacher certification and their preparation.

> Research indicates that when diagnosticians are asked to classify children, they are unable to agree on those children who are disturbed or those who are brain injured or often those who are retarded.
>
> To compensate and atone for the injustice thus perpetuated, State education departments spell out criteria for children to meet before acceptance into a special class program and provide financial inducements to local districts to establish programs. For added respectability, the States also spell out certification requirements for teachers to insure that the children secure competent aid and assistance. At this point, institutions of higher learning rush in to provide courses for tired teachers after school. But why sweat it. The teachers get their credits and credentials, the schools have approved programs and the state can point with pride to the existence of quality, competent programs.
>
> The courses that are offered emphasize the characteristics and needs of special groupings as though the children in special classes fit neatly into such clean, crisp categories. If the teacher is at all on the ball, he soon learns that the required courses too often have little to do with the job he has to do and the academic learning that takes place most often prepared him for a world that does not exist (pp. 26-27).

Lord (1967), in a critique of current classification practices proposed a major departure based upon the model of the rehabilitation center which offered service to all the handicapped. He discussed "a service centered school, less concerned with the medical diagnosis as a basis for classifying children and more interested in grouping children in terms of specific education and remedial needs (p. 53)." Although somewhat apprehensive towards the newer terms, such as, "Emotionally Disturbed and Neurologically Impaired," Lord also commented favorably on the label of "learning disabilities" as replacing the earlier use of the "brain injured" concept.

Obviously, as additional "categorical" groups of exceptional children were identified as in need of special education, i.e., learning disabilities, multi-handicapped, the above problems posed by Gallagher, Cruickshank, Trippee, and Lord were presenting serious challenges to local schools, state educational agencies, teacher educators, and federal funding sources. In our historical attempt to serve all children, we continue to add labels for identification purposes, develop new legislation for each presumably different group and supportive services, and then add to our teacher certification and preparation curricula to reflect these additions.

In spite of frequent expressions of concern over the growing categories of disability groups with their accompanying generalizations and standardizations, it remained for a unique set of circumstances to stem the tide. Professional, social, political, and judicial judgements occurred nearly simultaneously and stimulated the process of re-evaluation and the search for alternatives.

Clinical Teaching

Early expressions of possible alternatives to this growing dilemma were described by Kirk (1962), Lance (1966), Schwartz (1967a, 1967b), and Dunn (1968), all concerned with the education of the retarded and their teachers. Kirk's paradigm of "diagnosis and remediation of learning difficulties" stimulated Lance's definition of "clinical teaching . . . as a term denoting adequate diagnosis of individual needs and abilities, prescribing an educational program with specific, differential approaches to meet these specific needs of the individual, and the implementation of the program in the school setting (p. 100)." Schwartz traced the historical development of the "clinical teacher for special education" from 1866 to 1966 and advocated an "integrated" teacher education curriculum

focusing on the generic competencies of diagnosis and remediation for all teachers of exceptional children. Dunn clearly questioned the justification of special classes for children of diverse cultural backgrounds classified and labeled as "educable mentally retarded," and advocated the need for "clinical teaching."

Reflecting on a decade of rapid growth and growing concern over the efficacy of special education for mildly handicapped children classified as "educable mentally retarded (Goldstein, Moss, and Jordan, 1965)," Dunn stimulated a renewed interest in the "clinical approach," i.e., differentiating between the "regular educators" and the "special education program" for serving children with normal, mild, and severe learning difficulties.

> Existing diagnostic procedures should be replaced by expecting special educators, in large measure, to be responsible for their own diagnostic teaching and their clinical teaching. In this regard, it is suggested that we do away with many existing disability labels and the present practice of grouping children homogeneously by these labels into special classes. Instead, we should try keeping slow learning children more in the mainstream of education, with special educators serving as diagnostic, clinical, remedial, resource room, itinerant and/or team teachers, consultants, and developers of instructional materials and prescriptions for effective teaching (Dunn, 1968, p. 11).

Judicial Decisions

Concurrent with professional concerns over the efficacy of existing provisions for the education of exceptional children were parent associations and minority group advocates raising related questions. Local and state educational agencies were pressured through the courts to justify the constitutionality of existing testing, classification, and labeling practices with children. A series of judicial rulings; Hobson vs. Hansen (1967) in Washington, D.C., resulted in Judge Wright upsetting educational "tracking" provisions; Arreola vs. Board of Education (1968) in Orange County, California, specified parental involvement and the limitations in the testing and placement of exceptional children.

Subsequently, numerous court decisions (Ross, DeYoung, and Cohen, 1971; Vaughan, 1973) in behalf of exceptional children and their parents have dramatically altered public school special education provisions in California, Pennsylvania, and Massachusetts. The impact of these judicial

events coupled with an emerging professional concern facilitated the search for more effective services for a growing number of exceptional children, their families, and their teachers. The right to an education, for each individual child regardless of handicapping condition, is clearly on the way to becoming a reality (Gilhool, 1973).

PART II

ALTERNATIVES

The field has responded with an array of new concepts, models and practices that promise renewed optimism towards achieving the time honored aspiration of assisting each individual exceptional child to attain his maximum potential.

The fundamental rights of all children for quality educational opportunities have been reaffirmed. However the major changes are reflected in the *processses* for achieving these goals. New concepts and instructional systems for delivering innovative and alternative special educational services to a variety of exceptional children, new professional preparation programs designed to produce the varied competencies, and new evaluation strategies for improving instruction are highlighted in this section.

Goals

The "Basic Commitments and Responsibilites to Exceptional Children" (*Exceptional Children*, October, 1971), rededicates special educators to the following ideals:

1. All children have the right to a free quality education.
2. Quality education meets the needs of individual children.
3. The fundamental purposes of special education are the same as those of regular education.
4. Special education provides for those unique individual needs that cannot otherwise he met by regular education.
5. Special education programs are integral parts of a comprehensive school program.
6. Exceptional children should receive services based upon desired academic and social behaviors.
7. A variety of special educational services are necessary in every school system.
8. Teaching, research and service in colleges and universities should focus on the desired pupil behaviors and the professional competencies required to produce these behaviors.

Marland (1971) reaffirmed our nation's commitment to provide complete

and equal educational opportunities for all exceptional children and youth by 1980 indicating that of the approximately 7 million handicapped children identified as requiring special education only 40 percent now receive any such service. Davis and Wyatt (1971) reported that although an oversupply of teachers exists in our public schools, there remains a critical shortage of teachers with specialized competencies needed to serve handicapped children in both special and regular education. In addition to the persistent needs of exceptional children and their teachers are alternative special education provisions stimulated by ". . . a growing level of disappointment of disillusion with the existing system (Gallagher, 1971, p. 1)."

Changing Concepts

Categorical versus noncategorical issues (Meyen, 1971), innovative interrelated projects (Schwartz, et. al., 1972), mainstreaming (Reynolds and Davis, 1971), and alternative instructional services (Deno, 1973) for exceptional children and their teachers have been presented and debated at numerous state, regional, and national conferences. Supported by the USOE/BEH and NCIES, topical meetings conducted regionally have served to spotlight conceptual and programatic changes occuring in the field.

The categorical/noncategorical issue appeared to have been resolved at the 1971 conference conducted at the University of Missouri (Meyen). Consensus emerged suggesting a noncategorical approach for mildly handicapped children with learning problems, e.g., educable mentally retarded, learning disabilities, or emotionally disturbed with high probability of their return to regular classes. On the other hand, maintaining categories for more severely handicapped, e.g., severely retarded, blind and deaf, appeared feasible as they are less likely to be integrated into the regular class.

A variety of new models, systems and practices reflecting research and development activities supported by the USOE/BEH and BEPD were reported by Schwartz, *et.al.*, (1972). Of the twenty one projects reviewed, seven referred to competency based instruction while four utilized either computer assisted or computer managed instruction. The project trainees were being prepared to work with children of either preschool or school age; or indirectly with teachers, parents or other school personnel. Thirteen of the projects referred to the diagnostic-remedial approach to instruction for children with four utilizing contingency management techniques as their primary approach for children. Four other projects

advocated a task analysis or sequence of behaviors approach-selecting a desired objective after complete diagnostic evaluation and teaching the requisite skills to enable the learner to achieve the desired objective. The environments in which the trainees would function ranged from full-time special education classroom to part-time resource rooms, regular classroom, and special community facilities. Similarly, the target population of exceptional children served ranged from mild, moderate, to severely handicapped.

Reynolds and Davis, and Deno reported recent efforts in "improving the competencies of teachers who work with handicapped children in regular classrooms" through the support of the Office of Education, Bureau of Educational Personnel Development (USOE/BEPD) currently identified as the National Center for the Improvement of Educational Systems (NCIES). Characterized as "mainstreaming," this rapidly growing approach prepares regular classroom teachers and other school personnel in providing for handicapped children as an alternative to the "labeling," "self-contained special classes," and other practices of the past.

Although these controversial issues are by no means resolved, dramatic changes in the delivery of special education services and in the preparation of their teachers reflect these emerging concepts and practices.
MacMillan (1973) summarized "the issues and trends which have led special education to be in a state of transition (p. 3)" citing the critical issues confronting special education:

Mild Retardation and Minority Children
Noncategorical Approach for Delivery of Services
Avoidance of Deficit Labels
Responsibility of States to Provide Educational Programs for the Severely Retarded
Early Identification and Intervention
Accountability and Special Education
Assessment of Assessment Procedures
Use of Paraprofessionals

Instructional Alternatives

New systems, models, strategies and technologies for special education have rapidly emerged during the current decade. These changes offer viable

alternatives to existing practices and promise solution to the many dilemmas in the field.

> We need substantial changes to the entire system and not merely at the end product 'where the rubber meets the road,' or where the teacher meets the children. We need to change not just the tires, but to redesign the whole vehicle. Our attitude toward the whole delivery system of services must be altered (Gallagher, 1971, p. 1).

Several systems are described in the literature (Deno, 1970; Haring, 1970; and Schwartz, 1971) for redesigning services for exceptional children, special educational curricula, and for the preparation of teachers. Common components of the system are *objectives, procedures,* and *evaluation.* Design, try-out, feedback, and revision are on-going functions in each of the components for the continuous refinement and improvment of the instructional system.

As a system for producing desired changes, Deno (1971) (See Figure 1, p. 11) describes "The cascade system of special education service . . . required to control the learning variables deemed critical for the individual case (p. 235)." Suggesting a performance-based accountability model, this system provides for the feedback, revision and evaluation based upon the impact on children rather than upon the number served.

Placement within the "Cascade" is facilitated by critical decision-making variables identified by Reynolds and Balow (1972). Deno describes the "cascade system" as a "tapered design . . . to indicate the considerable difference in the numbers of children anticipated at the different levels . . . (p. 14)." Functioning as a "diagnostic filter," the system provides literally for all children.

> The cascade model assumes that children are seldom all able or all handicapped. They more frequently present their teachers with a marble cake of aptitudes and dysfunctions that cannot be adequately described by categorical classification of children on an 'he is or he isn't' basis. The organizational model recognizes that children need to be programmed individually, that the only fundamentally meaningful class, for educational purposes, contains an N of one (p. 16).

Figure 1. Deno's Cascade (1970, p. 235)

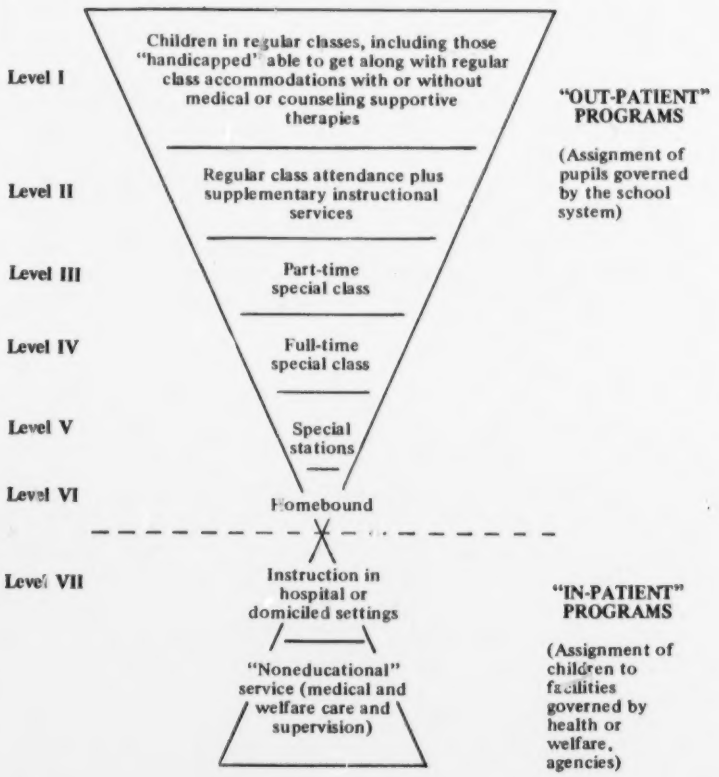

Level I
Children in regular classes, including those "handicapped" able to get along with regular class accommodations with or without medical or counseling supportive therapies
"OUT-PATIENT" PROGRAMS
(Assignment of pupils governed by the school system)
Level II
Regular class attendance plus supplementary instructional services
Level III
Part-time special class
Level IV
Full-time special class
Level V
Special stations
Level VI
Homebound
Level VII
Instruction in hospital or domiciled settings
"Noneducational" service (medical and welfare care and supervision)
"IN-PATIENT" PROGRAMS
(Assignment of children to facilities governed by health or welfare agencies)

FIGURE 1. The cascade system of special education service. The tapered design indicates the considerable difference in the numbers involved at the different levels and calls attention to the fact that the system serves as a diagnostic filter. The most specialized facilities are likely to be needed by the fewest children on a long term basis. This organizational model can be applied to development of special education services for all types of disability.

Haring (1970) presented a comprehensive review of contemporary scientific advances in "The New Curriculum Design in Special Education."

Stressing "the technology of teaching or teaching according to applied scientific principles of behavior (p. 30)," Haring forecasts a leadership role for Special Education in the emerging sophistication of instructional objectives, technology, and evaluation.

> New curriculum design in Special Education shows a convergence of two strong influences: 1) The recognition of the importance of individualized instruction; and 2) the growing effect of the procedures of experimental analysis with an emphasis on the individual child and the conditions which, when applied to well-defined behaviors, produce specific results. In contrast to the design of the curriculum of the past, the new design in the curriculum of special education is broader, possibly more content-oriented, certainly directed at the behavioral components of learning, totally defined in behavioral terms, and managed within a system (pp. 29-30).

PART III

CLINICAL TEACHER

Outcomes

Schwartz (1967, 1971) advocated and designed a new teacher education curriculum for Special Education synthesizing generic "clinical teaching" competencies of *individualizing instruction* for producing commonly desired behaviors in mildly handicapped exceptional children. Employing instructional systems, technology, and evaluation strategies, as the *procedures* for attaining the outcomes (teacher competencies and pupil behaviors), the "Clinical Teacher Model" for Interrelated Areas of Special Education offers a viable alternative to the dilemmas confronting the field. Behaviorally specified and measurable performance objectives for both the clinical teacher and the exceptional children to be served are defined within the individualized instructional system. Focusing on educationally desired pupil behaviors, rather than existing medical and psychological categories, the prototype program offers performance-based instructional modules monitored by a computer management system. The instructional system is designed to enable the clinical teacher, functioning within the learning resource setting of the "cascade of services," to produce the academic and social skills in mildly handicapped children required for their succeeding in the regular class. Evaluation and research designs, as an integral component in the system, will build the data base for documenting and disseminating the effectiveness of the clinical teacher model for Special Education.

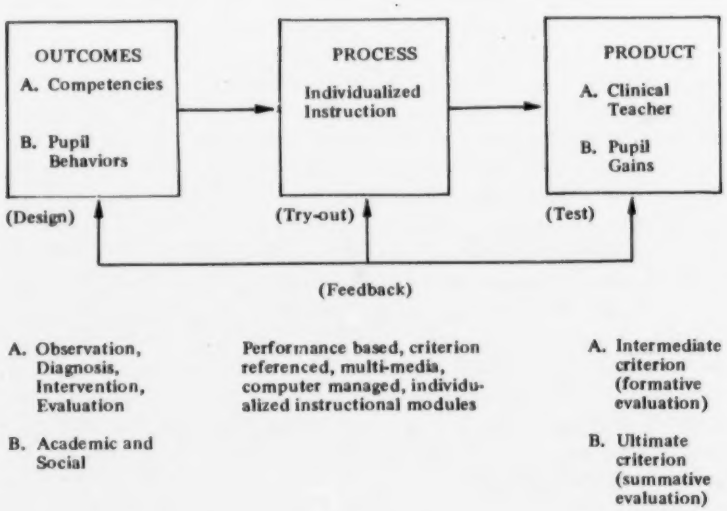
Procedures

Three essential elements of the system are the conceptual models, instructional strategies, and evaluation design. The conceptual model contains major goals and task analysis of the objectives necessary for their attainment. The instructional strategy specifies the explicit enabling objectives, resources selected and/or designed, assessment criteria for determining mastery, and test items for measuring attainment. The evaluation design provides formative and summative procedures and data for the on-going improvement of instruction. The relationship between demonstrated clinical teacher competencies and the produced pupil

behaviors in the target population of mildly handicapped children provides the documentation as to the effectiveness of the teacher preparation model as a viable alternative for the field.

The instructional system is presented in Figure 2.

Figure 2. Instructional System (Schwartz and Oseroff, 1972)



Performance-based teacher competences and behaviorally specified pupil objectives are contained within individualized instructional modules. The modules, generated from a task analysis of the objectives and the conditions under which they may be attained, is the unit of instruction for both the teacher education curriculum and the exceptional child behavioral continuums.

The strategy for designing modules was provided the Clinical Teacher Model by Dodl (1969), and is presented in Figure 3, page 15.

Figure 3. Task Analysis
(Dodl, 1969)

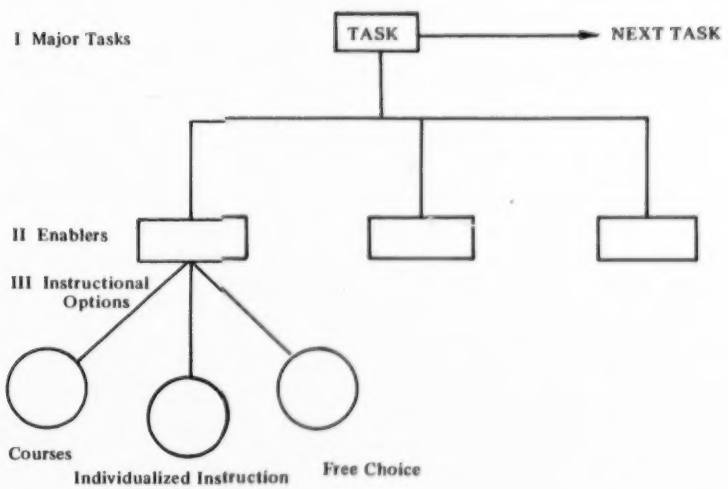


Figure 3 presents a conceptual model of the task analysis strategy employed in the clinical teacher program. The approach offered in this strategy reflects the intent to employ the computerized management control system available to the program. A teacher education model which was developed for use in the field of elementary education (Dodl, 1969) and was a product of an interdisciplinary team using a systems approach shows promise as a general model for teacher preparation. This model is sufficiently adaptable to the inter-related areas project to attempt its implementation in this program. Furthermore, time and effort would be saved by avoiding the costs of design and initial implementation. Such a model lends itself to the definition of specific evaluation procedures by its behavioral orientation.

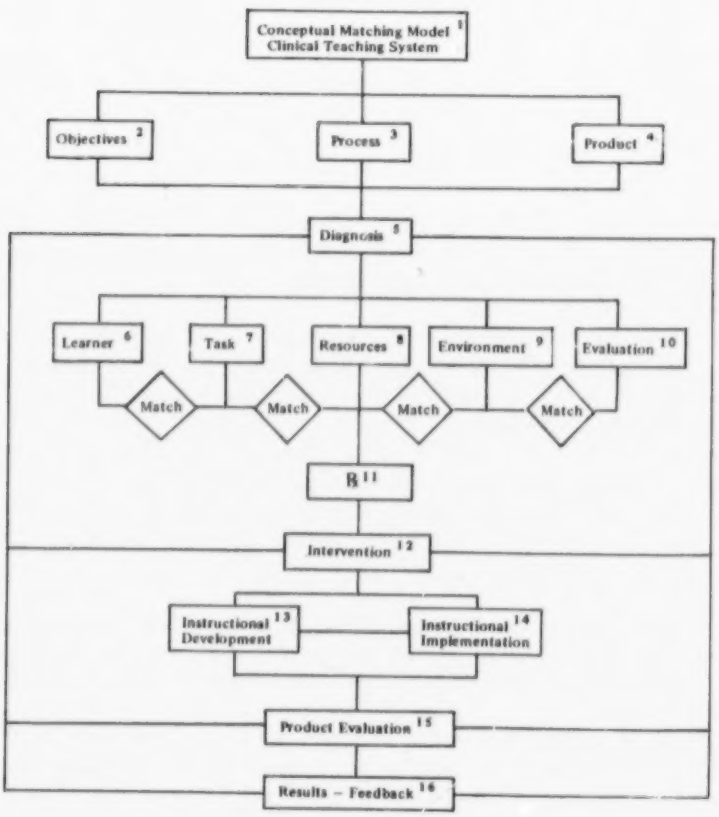
The model is shown simplistically in Figure 3. A basic assumption is that the goals in education of teachers can be described by defining competency areas known as Major Tasks. These tasks, in aggregate, constitute the definition of what the product of a teacher education program is—the very best teacher that it is possible to produce. In order

for the prospective teacher to learn and perform these major tasks he must have the requisite knowledge, experience, and skills which enable him to perform each task. These Enablers, as they are called, are a set of sub-objectives. The model provides for the existence of multiple sets of Instructional Options which will lead the prospective teacher toward being able to satisfactorily perform a behavioral objective.

Individualizing Instruction

The essential strategy for attaining the educational outcomes of the Clinical Teacher Model is the *process* of individualizing instruction. The Conceptual Matching Model for individualizing instruction is presented in Figure 4, page 17, with definitions on page 17 and 18.

Figure 4. Conceptual Matching Model
(R. Schwartz, 1973)



Definitions

1. The conceptual model of the Clinical Teacher System represents a visual display and narrative descriptors of objectives, process, and products of the interrelated elements and attributes of the instructional system.

2. The desired outcomes of special education for mildly handicapped children (educable mentally retarded, learning disabilities, and emotionally disturbed) are to produce the required academic and social

behaviors for succeeding in the regular classroom. The clinical teacher education program produces the teacher competencies of observation, diagnosis, intervention, and evaluation necessary to achieve these objectives.

3. The process-interactive component of the system provides individualized instruction based upon a MATCH of appropriate diagnosis, intervention, and evaluation that integrates the objectives, the process, and the products of the instructional system.

4. The Clinical Teacher produces and documents the behavioral gains in exceptional children, demonstrating the competencies through the use of the individualized instructional strategy.

5. Diagnosis is a continuous integrating matching of (1) learner entry level and characteristics, (2) task characteristics, (3) available resources and their charact ristics, (4) environmental characteristics, (5) evaluation activities.

6. Systematic observation and formal and informal assessment identifies and specifies individual learner (1) entry levels, (2) terminal objectives, (3) modes, styles, e.g., visual, auditory, kinesthetic, dependent, independent, time.

7. Analyzes and selects appropriate tasks matched to learner characteristics which specify the subordinate objectives in the sequence necessary for mastery of terminal objectives.

8. Selects available materials and strategies matched to learner and task characteristics for maximizing the effectiveness and efficiency for accomplishing the task.

9. Engineers learning environment, i.e., facilities, conditions, reinforcers for optimum management of instruction based upon learner, task, and resource characteristics.

10. Assesses student and instructional performance by selecting and/or designing appropriate measures.

11. Writes individual pupil profile based upon pre-instructional summary containing characteristics of learner, task, resource, environment, and evaluation items.

12. Plans and writes a performance contract based upon the diagnostic profile.

13. Selects and/or designs an appropriate instructional module.

14. Conducts the instruction, continually monitoring student performance and curriculum utilization.

15. Assesses changes in pupil behaviors in terms of the outcomes specified in the performance contract.

16. Reports curriculum effectiveness and efficiency by describing, documenting, and relating produced pupil gains to individualized instructional strategy.

Forecast

Mildly handicapped children with individual behavioral needs require a short-term specialized learning resource room. The clinical teacher systematically observes, diagnoses and transmits an educational profile containing pupil entry behaviors and desired behavioral objectives via a desk teletype terminal to a regional modulation center for analysis, prescription, and retrieval (Adamson and Van Etten, 1970). Within minutes, a computer print-out is returned containing instructional objectives, requisite subordinate skills, criterion measures, multi-media resources and options; field tested and matched for prescribed student performance.

The clinical teacher designs and manages the intervention strategy utilizing the packaged, programmed module with the individual student. The learner is provided appropriate instructional options and ongoing assessment. Both student and teacher chart progress towards desired outcomes. Product assessment, therefore, is the ultimate criterion measure of the efficacy of the individualized and personalized instructional system. Feedback to the modulation center modifies any of the components, and improves subsequent instructional packages, while building the data base for evaluation of instruction.

The computer managed instructional system provides the student and teacher with an ongoing record of performance in terms of clearly defined and measurable academic and social behaviors. Returning to the mainstream of regular class membership, the individual child performs the

behavior necessary for succeeding with his peers and may only occasionally require prescribed assistance from the clinical teacher in the learning resource room.

The forecast when fully operational, will fulfill the promises of the "brave new world" for Special Education . . . "It includes a compulsion on the part of instructional specialist to delineate clearly and meticulously the pedagogical steps and stages by which the learner is to achieve desired terminal behaviors (Blackman, 1964, pp. 29-30)."

PART IV

A USER'S GUIDE

This section contains student directions for using the individualized, performance-based, instructional modules of the program. Following a brief overview, program requirements and student responsibilities are provided in detail.

Individualized Instruction

Individualizing of instruction is the major *process* strategy employed in this program. The process is defined as (1) assessing individual learner entry level over pre-stated objectives, (2) negotiating the desired objectives, procedures, resources, and time-line for their attainment, and (3) criteria upon which judgements will be made concerning their successful completion.

This *process* encourages on-going evaluation between learner and teacher for the improvement of instruction.

Performance-Based Competencies

Performance-based competencies are a critical element in the *process* of individualizing instruction. The Clinical Teacher Competencies of OBSERVATION, DIAGNOSIS, INTERVENTION, and EVALUATION are demonstrated on four levels of proficiency. Early awareness, knowledge, performance, and product objectives are varying levels of performance-based competencies. Figure 5, page 22, presents the four levels. See Appendix A, page 30, for a detailed "Position Statement" concerning performance-based competencies.

Figure 5. Levels of Objectives for Performance-Based Teacher Education Programs

A. OUTCOMES	B. CRITERIA	C. CONTEXT
I. PRODUCT		
Pupil achievement and gains as a consequence or result of teacher action on the performance of pupils.	Time sampling of teacher behaviors and pupil achievement.	Employment (full-time) in actual classroom situation (1-2 yrs.), and Internship (1 quarter).
II. PERFORMANCE		
Teacher competencies and skills.	Assessment of the overt observable pedagogical skills and behaviors of the trainee to determine teaching mastery of the specified competencies.	Practicum (Quarterly) in actual classroom situation. Laboratory or simplified training conditions (days or weeks) of restricted or micro-teaching simulations.
III. KNOWLEDGE		
Understanding of behaviors, concepts, principles, and attitudes.	Assessment of knowledge, understandings, and attitudes of trainees.	Curricula content.
IV. EXPLORATORY		
Early awareness and orientation.	Not measured.	Activity or event in which to engage, i.e., visit a resource room in a local school and assist teacher and pupils for a minimum of 10 hours.

Instructional Modules

Instructional Modules are the units of instruction which systematically enable the trainees to acquire and demonstrate the clinical teaching competencies. Each module contains enabling objective(s) for attaining the major competencies. The module format presented in Figure 6, page 23, is numerically referenced and contains an estimate of standard student time required for mastery.

Figure 6. Module Format

Reference System: Time

Program

Competency

Module Cluster

Module

I Purpose–what the trainee is expected to accomplish

II Behavioral Objective–Levels of objectives (see Figure 5, page 22.)
- A) Module Outcome–Terminal Behavior
- B) Assessment Context–Conditions under which behavior will be performed
- C) Assessment Criteria–Proficiency Level

III Instructional Resources/Options/Activities–Faculty, Readings, Seminars, Multi-Media, Field Placements, etc.

IV Sample Test Items–Products, Papers, Essay Tests, Demonstrated Field Performance, etc.

Program Requirements

General degree and course requirements are available in the University *Bulletin* and College of Education *Programs in Teacher Education*. Specific program requirements for the specialization of Interrelated Areas of Special Education are presented as follows:

Major Specialization Sequence

I **Junior Year:**

I Qtr., Fall

Clinical Teacher Concept–Knowledge of Historical, Contemporary, and Future Aspects of Clinical Teaching.

II Qtr., Winter

Observation Skills–Knowledge and Performance of Systematic

Methods of Obtaining and Reliably Reporting Maturation, Academic, and Social Behavioral Data of Normal and Exceptional Children Ages Three to Twelve in Local Public Schools.

III Qtr., Spring

Diagnosis–Knowledge of Formal and Informal Assessment Instruments For Normal and Exceptional Children.

II **Senior Year:**

I Qtr., Fall

Diagnosis–Performance of Administration, Scoring, Interpretation, and Profiling of Normative and Criterion-referenced Tests with Exceptional Children in Local Public Schools.

II Qtr., Winter

Intervention–Knowledge and Performance of Planning, Conducting, and Documenting An Individualized Instructional Strategy for Producing Academic and Social Gains with Exceptional Children in Local Public Schools.

III Qtr., Spring

Evaluation–Knowledge of Assessing Pupil and Curriculum Performance Necessary for Determining the Effectiveness and Efficiency of the Strategy and for Building the Data Base for Improving Instruction.

III **Master's Year:**

Individually planned and negotiated graduate program of studies to include full-time (12 Qtr. Hr.) internship in a Special Education resource room in a public elementary school. Based upon the student's personalized needs assessment, the graduate program will be designed to relate to and improve clinical teaching competencies.

Other Course Requirements

The following courses, described in the University *Bulletin* and College of Education *Programs in Teacher Education* as of the 1972-73 academic year, are required:

HAS 305	Introduction to Habilitative Sciences (3)
HAS 326	Survey of Mental Retardation (3)
HAS 344	Oral Language Development (3)
HAS 345	Survey of Speech Problems (3)

HAS 406	Introduction to Vocational Rehabilitation (3)
HAS 416	The Disadvantaged Child (3)
HAS 417	Emotional and Social Problems of Children and Youth (3)
HAS 537	Problems of Children and Youth with Visual Disabilities (3)
HAS 580	History, Education and Guidance of the Deaf (3)
HAS 800	Master's Comprehensive Exam
EED 405	Classroom Organization and Pupil Evaluation (5)
EED 431	Reading in the Elementary School (5)
EED 446	Introduction to Educational Media (3)
EED 533	Correction of Reading Disabilities (6)
PSY 315	Child Psychology (3)
PSY 317	Educational Psychology (3)
PSY 317F	Educational Psychology Field Experience (1)
EDR 40[illegible]	Measurement and Evaluation in the Classroom (4)
FND 420	The Public School and the American Community (3)

Student Responsibilities

General "Student Rights and Responsibilities" are described in the current *Student Handbook*, Florida State University. Specific responsibilities for trainees in the Interrelated Areas of Special Education are unique to the program. The highly individualized, personalized, performance-based curriculum, emphasizing field-based practicum in local public schools, requires a high degree of personal and interpersonal skills. Independent learning, self-motiviation, personal reliability, social interactive skills with peers and faculty, with an awareness of consequences of behavior, are co-requisite skills for pre-professional educators in this program. Although these critical "complementary skills" are not explicitly specified as "competencies," they must be demonstrated throughout the campus and field-based portions of the program.

The process of individualizing instruction in the Interrelated Areas curriculum provides an unusual opportunity for student-faculty interaction. Performance-based instructional modules enabling the student to enjoy a high degree of independence in learning, simultaneously offer creative interactions in both seminars and faculty conferences. This

personalized feature requires students and faculty to relate to each other in a highly professional manner which models a desirable professional employment situation.

1. *Independent Learning* is the self-motivational pursuit of the specified competencies. Due to the depth of the comptencies required in each eight (8) quarter hour course in the Major Specialized Sequence, the student is responsible for planning and allocating sufficient time to meet required proficiency levels. Although the terminal competencies and objectives in the curriculum are faculty determined, students are encouraged to utilize a variety of instructional resources, options, and activities to attain and demonstrate the competencies.

2. *Seminars* provide the opportunity for specific types of faculty/student interactions. *Specific focus instructional* seminars and *reflective* seminars facilitate interaction even though the specific purposes of each differ. The *specific focus instructional* seminar is designed and directed by the faculty to provide instruction on specifically targeted issues. These issues generally serve to bring together (synthesize) the resources in the modules. In addition, students are encouraged both to identify topics for future seminars and conduct them if they desire. *Reflective* seminars are conducted in order to encourage a free-floating exchange of feelings and attitudes towards any program-related activity.

   Students are responsible for being prepared for meaningful in-depth discussion of *specific focus instructional* seminars. This means that students, knowing the scheduled topics, will have read the related resources in order to enter into meaningful discussions.

   Due to the nature of these scheduled seminars, i.e., synthesis of material unavailable elsewhere, students are responsible for attending *all* seminars.

3. *Resource Accessability* is provided in three locations. All resources are available both in the Interrelated Areas Resource-Seminar Classroom and in the Educational Resource Center of the College of Education Building. Selected books are placed on reserve each quarter in the FSU Library.

   Students are responsible for using these resources and identifying any resource needed but not available. In addition to the required

resources necessary to achieve mastery over objectives, optional resources and activities are encouraged and should be negotiated during student/faculty conferences.

4. *Field Placements* are critical activities in a performance-based teacher education program. It is in the field placements that students demonstrate performance and product objectives with varying degrees of faculty supervision. All three levels of Junior, Senior, and Master's Trainees are dependent upon the field resources for acquiring and demonstrating competencies. Explicit arrangements have been made with each cooperating school through the College of Education and local county school personnel.

   Students are responsible for following these agreements which include the following:

   1. On time arrival and sign in.
   2. On time departure and sign out.
   3. Appropriate dress as defined by each school.
   4. If unable to attend a scheduled field site, student must *call* before 9:00 a.m., both the school and Interrelated Areas offices.

   It is the trainees' responsibility, both professionally and personnally to "get along" with the cooperating teacher and all other school personnel. "On-task behavior" by the trainee facilitates "getting along" and increases the probability of successfully demonstrating clinical teacher competencies.

5. *Faculty Conferences, Negotiations, and Performance Contracts* are creative and interactive links between faculty and students in the performance-based curriculum. *Required* faculty/student conferences provide the framework for reviewing and facilitating student progress towards the attainment of specified objectives. The opportunity to negotiate optional objectives, resources, evaluation criteria, and time-lines are encouraged during these conferences. Performance contracts are the written agreements between faculty and students specifying the above.

   In addition, the student is responsible for arranging and following through on other conferences they may request. See Appendix B for Sample Performance Contract.

6. *Mastery Learning and Grading* are aspects of performance-based instruction. Although many objectives contain specified mastery levels and criteria, others specify "satisfaction of the instructor." The student can negotiate with the faculty the basis for the instructor's judgement. Mastery of the specified clinical teacher competencies in the curriculum is related to the FSU grade equivalents by a point system.

   Specific mastery criteria and accumulated points for the grading system for each quarter are presented in writing to each group of students at the first class meeting. Individual student negotiation and contract of both mastery criteria and grading system for the specific quarter is encouraged. See Appendix C for Sample Grading Scale.

   The student is responsible for knowing this mastery and grading system and its implications.

7. *Computer Management System* contains four reports: (1) Task Characteristics, (2) Learner Characteristics, (3) Student Performance, and (4) Summary. The management system is designed to collect data on student and curriculum performance and provides both faculty and students with information for monitoring progress as well as scheduling of instruction.

   The student is responsible for recording weekly, accurate information on the appropriate transaction forms for entering, updating, and completing modules. See Appendix D for Sample Logs.

APPENDICES

A. Position Statement of Performance-Based Teacher Education

B. Sample Performance Contract

C. Sample Grading Scale

D. Computer Management System Transaction Logs
   1. Module Entry Log
   2. Module Transaction Log
   3. Module Completion Log

APPENDIX A

Position Statement

1. Definition

A competency-based teacher education program specifies the competencies to be demonstrated by the student, makes explicit the criteria to be applied in assessing the student's competencies, and holds the student accountable for meeting these criteria. While at first glance this definition appears to depict a rather harsh, almost mechanistic process, nothing could be further from the truth. The competencies referred to are attitudes, understandings, skills, and behaviors that facilitate intellectual, social, emotional and physical growth in children. The student is held responsible for demonstrating these competencies, because they are necessary to teaching effectiveness. He may, however, help to determine either the competencies to be acquired, or the setting in which the competencies are to be demonstrated, or both. Three types of criteria are used to determine the student's level of achievement in these competencies: (1) knowledge criteria, which are used to assess the cognitive understandings of the student; (2) performance criteria, which are used to assess the teaching behaviors of the student; and (3) consequence criteria, which are used to assess the student's teaching effectiveness by examining the emotional and intellectual growth of his pupils.

(from James M. Cooper, Wilford A. Weber, and Charles E. Johnson, Editors. *Competency Based Teacher Education:2 A Systems Approach to Program Design*, Berkeley, Calif.: McCutchen Publishing Co., 1973, pp. 14-15)

2. Criteria

The AACTE Committee on Performance-Based Teacher Education has chosen to retain the term 'performance-based' in the belief that the adjective itself is relatively unimportant if there is consensus on the question of what elements are essential in distinguishing performance- or competence-based programs from others.

There now appears to be general agreement that a teacher education program is performance-based if:

1. Competencies (knowledge, skills, behaviors) to be demonstrated by the person completing the preparation program are:
   a. derived from explicit conceptions of teacher roles;
   b. stated so as to make possible assessment of a student's behavior in relation to specific competencies;
   c. made public in advance.
2. Criteria for assessing competencies:
   a. are based upon and are in harmony with specified competencies;
   b. make explicit expected levels of mastery under specified conditions;
   c. are made public in advance.
3. Assessment of the student's competence:
   a. uses his performance as the primary source of evidence;
   b. takes into account evidence of the student's knowledge relevant to planning for, analyzing, interpreting, or evaluating situations or behavior;
   c. strives for objectivity.
4. The student's rate of progress through the program is determined by demonstrated competence rather than by time or course completion.
5. The instructional program is intended to facilitate the development and evaluation of the student's achievement and competencies specified.

These are generic, essential elements, only professional training programs that include all of them fall within the AACTE committee's definition of performance-based teacher education.

(from Stanley Elam "Performance-based teacher education: What is the state of the art?" AACTE *Bulletin*, Vol. XXIV, No. 9, Dec., 1971, pp. 6-7)

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APPENDIX B

The Florida State University
College of Education
Division of Professional and Clinical Programs
Interrelated Areas of Special Education

PERFORMANCE CONTRACT

Trainee: _____ Date: _____

OBJECTIVE: _____

_____

_____

CONTEXT: _____

_____

CRITERIA: _____

_____

Due Date: _____

Trainee _____

Cooperating Teacher _____

Clinical Professor _____

Pass _____

Fail _____

COMMENTS:

APPENDIX C

Sample Grading Scale for HAS 370A

Activity		Point Value
Seminar attendance	10 pt. (ea.)	100
Computer logs (weekly updates)	10 wk	60
Essay tests (3) possible –		300
Project (See Requirements below)		200
Complementary Skills		100

Point Conversion for Grades

A = 600-760
B = 475-599
C = 400-474
D = Below 399

Project Requirements

Synthesis classifies objectives that are concerned with the learner's production of a unique response to an Application task–that is, unique to him. His response would be based upon his synthesis of responses from one or more of the sub-categories below:

Production of a Unique Communication.
Objectives related to the development of a communication in which the writer or speaker attempts to convey ideas or feelings to others.

Production of a Plan or Proposed Set of Operations.
Objectives related to the development of a plan or proposal.

Derivation of a Set of Abstract Relations.
Objectives that require a combining of abstract elements into a new product.

The individual must complete the elements according to his relevant knowledge so that he can produce the appropriate product demanded by the application task–but the response must have unique characteristics.

The response can satisfy this objective once only. If the desired response is to be routine, the objective is classified at the Application level.[1]

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[1] *Handbook of Curriculum Design for Individualized Instruction A Systems Approach*
Sidney J. Drumheller
Educational Technology Publications, Englewood Cliffs, New Jersey
p. 20, 21, 1971.

APPENDIX D

THE FLORIDA STATE UNIVERSITY

CLINICAL TEACHER MODEL

MODULE ENTRY LOG

NAME _____ CURRENT DATE _____

1) Student-Module Identification No. (C2):

_____ _ _ _ _ _ _ _ _

Module No. (3 Digits) Social Security No.

2) Date of Module Entry (DE): _____/_____

Month (2 Digits) Day (2 Digits)

3) Resources Utilized (Please spell correctly) (RU):

(1) _____ (2) _____

(3) _____ (4) _____

(5) _____ (6) _____

4) Time Spent (to the nearest 1/10 hour) (TIME):

_____

. . . . . .

THIS SECTION FOR INSTRUCTOR USE ONLY

Pupil Styles (STYLE):

(1) _____ (2) _____ (3) _____

Individualized Instructional Strategy (IIS):

_____

1 – Entry

THE FLORIDA STATE UNIVERSITY

CLINICAL TEACHER MODEL

MODULE TRANSACTION LOG

NAME _____ CURRENT DATE _____

1) Student-Module Identification No. (C2):

_____ _ _ _ _ _ _ _ _

Module No. (3 Digits) Social Security No.

2) Resources Utilized (Please spell Correctly) (RU):

(1) _____ (2) _____

(3) _____ (4) _____

(5) _____ (6) _____

3) Time Spent (to the nearest 1/10 hour) (TIME):

_____

. . . . . .

THIS SECTION FOR INSTRUCTOR USE ONLY

	Product (PROD)	Product Proficiency (OBPRO)
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

2 – Trans

THE FLORIDA STATE UNIVERSITY

CLINICAL TEACHER MODEL

MODULE COMPLETION LOG

NAME _____ CURRENT DATE _____

1) Student-Module Identification No. (C2):

_____ _ _ _

Module No. (3 Digits) Social Security No.

2) Resources Utilized (Please spell correctly) (RU):

(1) _____ (2) _____

(3) _____ (4) _____

(5) _____ (6) _____

3) Time Spent (to the nearest 1/10 hour) (TIME):

_____

.....

THIS SECTION FOR INSTRUCTOR USE ONLY

	Product (PROD)	Product Proficiency (OBPRO)
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

Module Proficiency (MODPRO): _____

Date of Module Completion (DC): _____ / _____

Month (2 Digits) Day (2 Digits)

3 -- Compl

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